EXTENSIONS OF REMARKS

COMBAT VETERANS MEDICAL EQUITY ACT

HON. TOM BLILEY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 2, 1999

Mr. BLILEY. Mr. Speaker, today I rise to reintroduce the Combat Veterans Medical Equity Act. This legislation guarantees eligibility for Veterans Administration (VA) hospital care and medical services based on the award of the Purple Heart Medal. It also sets the enrollment priority for combat injured veterans for medical service at level three—the same level as former prisoners of war and veterans with service-connected disabilities rated between 10 and 20 percent.

Most people are unaware that under current law, the Purple Heart does not qualify a veteran for medical care at VA facilities. This bill would change the law to ensure combat-wounded veterans receive automatic access to treatment at VA facilities.

We as a nation owe a debt of gratitude to all our veterans who have been awarded the Purple Heart for injuries suffered in service to this country. This bill is long overdue and I am proud to sponsor this bill for our Nation's Purple Heart recipients.

This bipartisan legislation has over 100 original cosponsors and has been endorsed by the Military Order of the Purple Heart.

IN MEMORY OF ANTHONY J. CELEBREZZE

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 2, 1999

Mr. KUCINICH. Mr. Speaker, I rise today to honor the memory of a great servant of the people of Ohio, Judge Anthony J. Celebrezze. Celebrezze served Ohioans for over five decades. His recent death at the age of 88, is a sorrowful event for myself and many in my state.

Born in Anzi, Italy, Celebrezze emigrated to Cleveland at the age of two. He was one of 13 children. Like so many immigrants, Anthony Celebrezze grew up with modest means, but what he lacked in advantages he more than made up for in effort and ability. He worked his way through college at John Carroll University and through law school at Ohio Northern.

In 1950, Anthony was elected to the Ohio Senate. Three years later he was elected mayor of Cleveland. He was the first foreign born mayor of Cleveland. For an unprecedented five terms Anthony Celebrezze tirelessly served the people in this position. His leadership of the city brought Cleveland national recognition and respect. In 1962, he was appointed by President John F. Kennedy to the Secretary of the U.S. Department of Health, Education and Welfare. Anthony Celebrezze worked to build Congressional support for Medicare and the Civil Rights Act of 1964, two legislative achievements that reflect the principles of compassion and decency.

In 1965, he was appointed by President Johnson to a federal judgeship. Six years later the Federal Building in Cleveland was renamed the Anthony J. Celebrezze Federal Building. He was in the public eye for five decades, serving Ohio and the nation with honor and dignity. President Johnson said of Celebrezze that ''with tolerance and energy with single minded purpose, he presided over the greatest thrust for the future of American education and health that his nation has ever known.''

Judge Celebrezze was my role model, a man whose love of family and his community was never ending. I will never forget his warm smile, his friendly greetings, and his sense of decency, honesty and fairness. I am proud to have known him, and I think of him often. I, like many other Ohioans, will miss him terribly.

I ask you to join me in honoring the memory of this great man, Anthony J. Celebrezze. He will be greatly missed.

THE MEDICARE+CHOICE IMPROVEMENT ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 2, 1999

Mr. STARK. Mr. Speaker, I rise today with a number of my colleagues to introduce The Medicare+Choice Improvement Act. I don't need to tell you that the large number of Medicare+Choice plan terminations this past year was a real shock to many of our Medicare beneficiaries. In a number of communities, beneficiaries are left with fewer affordable coverage options in Medicare.

We should take immediate steps to make changes to the Medicare+Choice program that will protect beneficiaries when health plans leave the program, and we should make certain improvements that will aid health plans' abilities to project costs and continue as Medicare providers. I disagree with assertions that the only way to do this is to throw more money into the Medicare+Choice program and will oppose efforts of that nature.

History always has had a way of getting distorted and the Medicare+Choice program is a fine example of that happening. Let us remember, the Medicare+Choice program was created as part of the Balanced Budget Act. In other words, the purpose of creating the Medicare+Choice program was to save money in the Medicare program.

We have known for years that our payment system for Medicare managed care plans overcompensated them for the risk of the patients they were insuring. Medicare HMOs have historically insured younger, healthier seniors. Because Medicare's payment to managed care plans was based on the average fee for service payment in the county, the HMO payments were higher than appropriate. We also know that there are a number of other ways in which we are still overcompensating Medicare managed care plans. A chart highlighting these current overpayments is attached.

So, rather than rewrite historical evidence to advocate increased funding of the Medicare+Choice program, I have put together The Medicare+Choice Improvement Act to make important consumer protection improvements in the Medicare+Choice Program. The bill would:

Broaden consumer protections so that beneficiaries can leave health plans that have announced that they are terminating Medicare participation and join another Medicare+Choice plan to purchase a Medigap policy;

Provide new protections for Medicare's disabled and ESRD patients.

Prohibit door-to-door cold-call marketing of Medicare+Choice plans to seniors;

Protect state efforts to provide comprehensive prescription drug benefits to their seniors;

End Medicare+Choice plans' abilities to gerrymander their Medicare service areas in comparison to their commercial business;

Require HCFA to calculate the portion of beneficiaries in a region receiving services through VA or DOD;

Require the NAIC to reconfigure the Medigap policies so that they better meet the needs of today's Medicare beneficiaries.

On the health plan side of the equation, my legislation would take care of one of their most pressing concerns: it would move the ACR submission date (the date that health plans must submit their pricing and benefit data for the following year to HCFA) from the current date of May 1 to July 1. This would give health plans two additional months to compile necessary data for the upcoming year. This might not move the date as far as health plans would like, but there are serious costs to move the date further in the year. As one example, moving the date any later would seriously jeopardize the ability of HCFA to prepare the ''Medicare&You'' beneficiary handbook which is mailed to seniors each year.

On the topic of risk adjustment, I think that HCFA's proposal to phase-in risk adjustment over the next five years is just too long. We have solid evidence that Medicare managed care plans have been enrolling healthier patients and making more money off of them because of that fact (again, see the attached chart). The hospital-based risk adjustment proposed by HCFA is a first step toward fixing this inequity. It would finally put in place a financial incentive to enroll less healthy beneficiaries. We need to be moving forward as quickly as possible with this mechanism. I do concede that a phase-in approach is appropriate, but my legislation would have that phase-in occur over three years rather than five.